

CHAPTER 2

SECTION 1.1

DATA REPORTING - TRICARE ENCOUNTER DATA RECORD SUBMISSION

1.0. GENERAL

1.1. TRICARE Encounter Data (TED) Records provide detailed information for each treatment encounter and are required for TMA healthcare and financial reporting. A TED Record is submitted as either an institutional or non-institutional record. Institutional TED Records usually reflect a treatment encounter created by the formal acceptance of a hospital or other authorized institutional provider of a TRICARE beneficiary for the purpose of occupying a bed with the reasonable expectation that the patient will remain on inpatient status at least 24 hours with a registration and assignment of an inpatient number or designation. Institutional TED records may also reflect outpatient care in a Hospice or Home Health Program. This outpatient care is clearly identified by the Type of Institution code. A non-institutional TED record reflects either inpatient or outpatient health care services exclusive of inpatient institutional facility services.

1.2. All elements of the TED records must be maintained in the contractor's claims history file. The claims history will reflect the data submitted to TMA on the TED Record including resubmissions and adjustments; it will also contain all data necessary to reproduce a TED record as required by this manual and to reproduce an EOB, if required.

1.3. All other treatment encounter data including institutional care in connection with ambulatory surgery must be reported on a non-institutional TED Record.

1.4. There are three types of TED Records:

1.4.1. Initial Submission

1.4.2. Adjustment Submission

1.4.3. Resubmission

1.5. These types of records are discussed briefly in the following paragraphs. Complete record layouts, data requirements by Element Locator Number (ELN), and edit criteria are detailed in [Chapter 2, Section 2.4](#) through [2.9](#).

1.6. TED Records within a day's cycle are processed by TMA first in Filing Date order, then by TYPE OF SUBMISSION (I, O, D, R first; A, B, C, E second).

2.0. INITIAL SUBMISSION OF TED RECORDS

Initial submission applies only to the **first** submission of a **new** TED Record. Initial submissions are identified by TYPE OF SUBMISSION codes 'I', 'D', and 'O' on the TED Record.

2.1. All data indicated as "required" in the data element definition must be reported. If not received in the treatment encounter data, this data must be developed.

2.2. All signed numeric data elements on the initial submission must be reported as positive values.

2.3. When institutional TED Records are reported for other than the complete inpatient hospital stay, i.e. inpatient RTC care, the TED Records must be reported to TMA in the sequence that the care was provided (FREQUENCY CODES, 2-Initial, 3-Interim or 4-Final).

3.0. SUBMISSION OF ADJUSTMENT/CANCELLATION TED RECORDS

3.1. Adjustment submission applies to previously submitted and accepted TED Records which require adjustment because of processing errors or the need to update prior data with more current/accurate information. Adjustments to a complete denial or cancellation TED Record are not permitted. Previously denied or cancelled TED Records must be submitted as a new initial submission. The exception is adjustments to correct provisionally accepted denied or cancelled TED Records. The adjustment must only correct the relational edit errors and no changes can be made which would alter the original type of submission.

3.2. The adjustment/cancellation must be submitted on the same **header** type (batch or voucher) as the original submission.

3.3. Adjustment/Cancellation submissions are identified by TYPE OF SUBMISSION codes 'A', 'B', 'C', and 'E' on the TED Record. The use of the proper code is essential to accurate processing of adjustments.

3.4. Adjustment/cancellation conditions include, but are not limited to, the following:

3.4.1. Error in information received from the provider or beneficiary

3.4.2. Late submission of data from providers

3.4.3. Error in processing by current or prior contractor (if applicable)

3.4.4. Deductible corrections

3.4.5. Successful recoupment of monies, or receipt of a refund from the provider, beneficiary, or third party

3.4.6. Stale dated payment checks

3.4.7. When health care is charged to the wrong risk category (i.e., financially underwritten vs. non-financially underwritten) the original record must be cancelled and resubmitted under the correct risk category.

3.5. Adjustment submissions are **positive** (where additional monies are being paid by the contractor), **negative** (where monies are being credited back to the contractor), or **statistical** (serve to correct prior information but have no impact on payment amount).

NOTE: Adjustments to a complete denial or cancellation TED Record are not permitted. Previously denied or cancelled TED Records must be submitted as a new initial submission. The exception is adjustments to correct provisionally accepted denied or cancelled TED Records. These adjustments must only correct the relational edit errors and no changes can be made which would alter the record's type of submission.

If an adjustment results in the net effect of a complete cancellation (i.e. where the AMOUNT ALLOWED, AMOUNT GOVERNMENT PAY, and AMOUNT PATIENT COST SHARE = zero, and all line items are denied) of the TED, the adjustment must be reported with TYPE OF SUBMISSION codes 'C' or 'E'. Refer to "Examples" following for an example of a complete cancellation TED Record. Complete cancellation of TYPE OF SUBMISSION 'O' (zero payment TED Record due to 100% reimbursement by other sources) is not permitted unless an adjustment TED Record(s) has been submitted with the net effect on AMOUNT PAID BY GOVERNMENT CONTRACTOR being greater than zero.

All adjustment(s) (routine and provisional error corrections) to a non-TED Record (TYPE OF SUBMISSION codes 'B' or 'E') must be reported using TYPE OF SUBMISSION codes 'B' or 'E'.

3.6. Examples of adjustment submissions are located following. Example [paragraph 3.6.3.1.](#) portrays a positive adjustment, example [paragraph 3.6.3.2.](#) portrays a negative adjustment, and example [paragraph 3.6.3.3.](#) portrays an adjustment correcting information without impact on payment amount.

3.6.1. All adjustment submissions must be reported using the TED RECORD INDICATOR reported on the initial submission TED Record, regardless of the number of adjustments to the initial TED Record. However, an adjustment that would result in submission of a different record category (e.g., change an institutional record, type 1, to a non-institutional record, type 2) is not permitted. In this instance, the initial TED Record must be completely cancelled (TYPE OF SUBMISSION code 'C'), and a new initial TED Record submitted with the correct data.

3.6.2. All data as reported on the initial TED Record must be resubmitted except for signed numeric fields, and those numeric fields requiring correction. Data contained within each line item in the variable portion of the adjustment TED Record must be reported in the same sequence, with the same LINE ITEM NUMBER as on the initial TED Record. An adjustment TED Record can add additional detail line items, but cannot remove previously reported line items. All signed numeric fields and those non-signed numeric fields requiring correction must be reported according to the following:

3.6.2.1. All signed numeric data elements affected by the adjustment must reflect the **net difference** between what was **initially** reported and the **correct** amount. If adjustments were made in signed numeric fields prior to the current adjustment, the data elements must reflect the net amounts after combining the amounts in the initial and all prior adjustment submissions with this submission. Those signed numeric data elements that are unaffected by the adjustment netting process must be set to zero.

3.6.2.2. Numeric data elements requiring correction or update must reflect the most current information applicable to the service(s) being reported. All other numeric data elements must be reported as on the initial submission, or if prior adjustments corrected/updated the initial data, the data from the most recent submission must be reported.

3.6.2.3. Adjustment and complete cancellation TED Records are matched and applied to their corresponding initial submission TED Record and any other adjustment TED Records at TMA using the TMA database which consists of all TED Records and HEALTH CARE SERVICE RECORD INDICATOR table. The resulting "net" TED Record is completely edited through the TMA edit system as if it were an initial submission TED Record. Thus, the original and any prior adjustments must have passed TMA validity edits before a new adjustment is reported.

3.6.3. Examples

3.6.3.1. Positive Adjustment

A TED Record was submitted by the contractor and processed by TMA with an amount billed of \$200.00, amount allowed of \$100.00, and \$50.00 applied to the deductible. The amount allowed should have been \$180.00 and no monies should have been applied to the deductible. The amount billed, however, was unchanged.

INITIAL TED RECORD POSITIVE ADJUSTMENT AMOUNTS

INITIAL TED RECORD	
Amount Billed	\$200.00
Amount Allowed	100.00
Amount to Deductible	50.00
Amount Paid (75%)	37.50
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	80.00
Amount to Deductible	-50.00
Amount Paid (75%)	97.50
EFFECT AT TMA	
Amount Billed	200.00
Amount Allowed	180.00
Amount to Deductible	0
Amount Paid	135.00

3.6.3.2. Negative Adjustment

A TED Record was submitted by the contractor and processed by TMA with an amount billed of \$500.00, an amount allowed of \$500.00, and amount paid by the contractor of \$500.00. However, other health insurance (OHI) was involved and their payment of \$400.00 was recouped. The amounts billed and allowed were correct but the amount paid should have been \$100.00.

TED RECORD NEGATIVE ADJUSTMENT AMOUNTS

INITIAL TED RECORD	
Amount Billed	\$500.00
Amount Allowed	500.00
Amount to OHI	0
Amount Paid	500.00
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	0
Amount to OHI	400.00
Amount Paid	- 400.00
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Amount to OHI	400.00
Amount Paid	100.00

3.6.3.3. Statistical Adjustment

A TED Record was submitted by the contractor and processed by TMA for a hospitalization spanning twenty (20) bed days and \$2,000.00 in billed charges. Fifteen (15) of the days were considered authorized. Subsequently, the total number of bed days was found to be thirty (30) and billed charges were actually \$3,000.00. However, the allowable days and amount paid by the contractor remained unchanged.

TED RECORD STATISTICAL ADJUSTMENT

INITIAL TED RECORD	
Amount Billed	\$2,000.00
Amount Allowed	1,500.00
Covered Days	15
Amount Paid (75%)	1,125.00

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 1.1

DATA REPORTING - TRICARE ENCOUNTER DATA RECORD SUBMISSION

TED RECORD STATISTICAL ADJUSTMENT (CONTINUED)

ADJUSTMENT TED RECORD	
Amount Billed	1,000.00
Amount Allowed	0
Covered Days	0
Amount Paid	0
EFFECT AT TMA	
Amount Billed	3,000.00
Amount Allowed	1,500.00
Covered Days	15
Amount Paid	1,125.00

3.6.3.4. Negative Adjustment (Complete Cancellation)

A TED Record was submitted by the contractor and processed by TMA with an amount billed of \$500.00, allowed of \$500.00, and amount paid by government contractor of \$375.00. Subsequently, the contractor processed an adjustment to pay in full, reporting an increase of \$125.00 in the amount paid by government contractor. The contractor then determined the care was processed in error and recouped the entire \$500.00 payment.

TED RECORD NEGATIVE ADJUSTMENT

INITIAL TED RECORD	
Amount Billed	\$500.00
Amount Allowed	500.00
Patient Cost-Share	125.00
Amount Paid	375.00
Covered Days	5
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	0
Patient Cost-Share	-125.00
Amount Paid	125.00
Covered Days	0
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Patient Cost-Share	0
Amount Paid	500.00
Covered Days	5

TED RECORD NEGATIVE ADJUSTMENT (CONTINUED)

CANCELLATION TED RECORD	
Amount Billed	0
Amount Allowed	-500.00
Patient Cost-Share	0
Amount Paid	-500.00
Covered Days	-5
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	0
Patient Cost-Share	0
Amount Paid	0
Covered Days	0

4.0. RESUBMISSION OF TED BATCH/VOUCHERS AND TED RECORDS

4.1. Batches/vouchers that fail any edits at the header record level will be rejected and returned to the contractor for correction. Header level rejections require the resubmission of the entire batch/voucher with the appropriate data corrections. The RESUBMISSION NUMBER must not be incremented from what was reported on the prior submission.

4.2. Institutional and Non-Institutional Records which fail relational edits will be “provisionally” accepted on the TMA TED database, and returned to the contractor for correction. Provisionally accepted records must be corrected and resubmitted as an adjustment, in a new voucher/batch.

4.3. Institutional and Non-Institutional Records which fail validity edits will be rejected and returned to the contractor for correction and resubmission. All returned records which fail the validity edits within a **voucher** must be returned by the contractor at the same time and balance to the outstanding TOTAL AMOUNT PAID and number of outstanding records at TMA. All returned records which fail the validity edits within a **batch** must be returned by the contractor at the same time and balance to the outstanding number of records. Upon resubmission, the records will again be processed through the TMA editing system. Resubmission's are identified by the BATCH/VOUCHER RESUBMISSION NUMBER in the Header Record. Resubmission applies to all Institutional and Non-Institutional TED Records which have failed to pass the TMA validity edits.

4.4. Resubmissions must be reported using the TED RECORD INDICATOR reported on the initial or adjustment TED Record, regardless of the number of times the TED Record is resubmitted.

4.5. All data as reported on the initial or adjustment TED Record must be resubmitted except for that data changed in order to correct the error(s).

4.6. If the rejected TED Record is TYPE OF SUBMISSION = ‘I’ (initial), report the correction TED Record with TYPE OF SUBMISSION = ‘R’ (resubmission). All other TED

Record TYPE OF SUBMISSION codes retain their original code throughout the resubmission process.

4.7. To liquidate or “clear” a voucher, both TOTAL AMOUNT PAID and the number of outstanding TED Records must zero out. When a TED Record passes editing (including provisionally accepted records), the TOTAL NUMBER OF RECORDS and the TOTAL AMOUNT PAID submitted on the original voucher are decremented. A voucher “clears” when both totals reach zero.

4.8. To liquidate or “clear” a batch, the number of outstanding TED Records must zero out through the edit error correction and resubmission process.

4.9. If TMA edits identify that the dollar amounts on the voucher are incorrect, the contractor must correct the related monetary data to balance to the AMOUNT PAID BY GOVERNMENT CONTRACTOR reported on the TED Record. **Do not change the AMOUNT PAID BY THE GOVERNMENT CONTRACTOR.** Correction of the payment error will be reflected through your processing and subsequent submission of the adjustment/cancellation TED Record.

5.0. INTERIM INSTITUTIONAL PAYMENTS

In certain cases, providers can submit interim bills for institutional claims. All TED Records for interim (interim or final) institutional bills must be submitted as an adjustment using the same ICN as the initial submission.

6.0. PROCESS FOR REPORTING RESOURCE SHARING AND CAPITATED TREATMENT ENCOUNTERS TO TMA

The following process is to be used by claims processors to submit data to TMA which relates to Resource Sharing or Capitated Treatment Encounters.

6.1. SPECIAL PROCESSING CODE

For Resource Sharing and/or Capitated claims/encounters, submit a TED Record which includes the appropriate SPECIAL PROCESSING CODE, as defined in [Chapter 2, Section 2.8](#), for each patient encounter.

6.2. “Amount” Field Reporting

The “amount” fields must contain the following:

6.2.1. AMOUNT BILLED/AMOUNT BILLED BY PROCEDURE CODE

The AMOUNT BILLED/AMOUNT BILLED BY PROCEDURE CODE fields shall be the amount (institutional or noninstitutional charges) that the capitated provider would charge a patient on a capitated basis. If a Resource Sharing provider is being reimbursed on a fee-for-service basis with negotiated/discounted rates, report these amounts.

6.2.2. AMOUNT ALLOWED/AMOUNT ALLOWED BY PROCEDURE CODE

The AMOUNT ALLOWED/AMOUNT ALLOWED BY PROCEDURE CODE fields must contain the appropriate DRG or per diem for institutional services, the CHAMPUS Maximum Allowable Charge (CMAC) for noninstitutional services, or negotiated/discounted rates for both institutional and noninstitutional services.

6.2.3. AMOUNT PAID BY GOVERNMENT CONTRACTOR

The AMOUNT PAID BY GOVERNMENT CONTRACTOR field must equal the “lesser” of the amount allowed minus (PATIENT COST-SHARE plus AMOUNT APPLIED TOWARD DEDUCTIBLE) or AMOUNT ALLOWED minus amount of OHI. If the “Lesser” computed amount is negative, AMOUNT PAID BY GOVERNMENT CONTRACTOR must = \$0.00.

7.0. PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA

The following process is to be used by claims processors to report claim-related data to TMA which contain charges for blood clotting factor.

7.1. Blood Clotting Factor

Data is to be reported on the Institutional TED Record, even though they are to be reimbursed separately from the DRG methodology.

7.2. Calculation of Charge

Charges will be calculated in a two-step process, as described below.

7.2.1. First Step

The DRG-reimbursable hospital charges will be calculated in the normal way. All related financial data will be stored for later use (see below).

7.2.2. Second Step

The blood clotting factor financial data will be calculated based on the reimbursement methodology described in the Policy Manual. All related financial data will be stored for later use. Revenue Code 636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor only. All other drugs are to be reported using the appropriate Revenue Codes in the 25X series.

7.2.2.1. The number to be coded in the UNITS OF SERVICE field is the number of units billed on the claim, not the number of payment units (which is 100 times the number of units billed).

7.2.2.2. The billed charges for blood clotting factor are to be reported in the TOTAL CHARGE BY REVENUE CODE field of the payment record.

NOTE: While blood clotting factor charges will be priced separately, the DENIAL REASON CODE cannot be 'F' (DRG non-reimbursables).

7.2.3. Data Reporting

From the two steps above, merge the financial data as follows, and enter them into the appropriate cost fields:

7.2.3.1. Amount Billed

This is the sum of all billed charges **including** those for blood clotting factor.

7.2.3.2. Amount Allowed

This is the sum of the two separate amounts allowed resulting from the calculations in step 2 above.

7.2.3.3. Amount of Other Health Insurance

This is the amount paid by other primary sources of reimbursement, if applicable.

7.2.3.4. Patient Cost-Share

Enter in the appropriate field based on the Category of Beneficiary:

7.2.3.4.1. Patient Cost-Share (For Other Than Family Members of Active Duty)

This is the amount based on either 25% of the billed charges (including those for blood clotting factor) or the per diem amount times the number of days in the hospital stay.

7.2.3.4.2. Patient Cost-Share (For Family Members of Active Duty)

This is the amount based on the inpatient hospital daily rate times the number of days in the hospital stay.

7.2.3.5. Amount Paid By Government Contractor

This is the sum of the two separate amounts resulting from the calculations in step 2 above.